Continuum of Care Reform
Fiscal Workgroup Meeting Minutes
February 5, 2014

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Presentation by DSS staff of a statewide "One Residential Care Base Rate" model

- In-depth overview draft document titled "Residential Care Fiscal Model."
- Please see the attachment "2014 - 02-05 - DRAFT Residential Care Rate.pdf"

One Board and Care Rate for All Group Home providers

- High level overview of the on rate board and care rate methodology with sample numbers for demonstration only.
    - Note that the numbers are place holders and do not reflect the current thinking of what the amount of the rate would be, only a method to determine what the rate would be.
- Only looking at the Title IV-E funded components of group home care and supervision, not treatment and social service activities.
    - Assume that there is a 3:1 youth to staff ratio during the day and a 6:1 ratio at night.
    - Occupancy rate at 90%.
    - Includes the cost of training.
    - Staff benefits are assumed to be at 30%.
    - Assume that 50% of staff time is involved in counseling activities.
        - Providers stated that this estimate was too high.
- It was noted that it is important to include probation in the discussion.
- Questions regarding the variability in services and supports will be answered at a later date.
    - There is a subgroup working with DHS and DSS

Please send comments and recommendations to the CCR unit: CCR@dss.ca.gov

Residential Care Fiscal Model

Continuum of Care Reform Unit

February 2014

Purpose

The California Department of Social Services (CDSS) will develop a fiscal model for residential care that maximizes federal funding and allows for flexibility and resources for individualized care.

Overview

Throughout California, in nearly every foster care case there are three main categories of provisions: the child's physical location or "living situation," mental health treatments and therapies, and services and supports to the child and his/her family in the community. In order for the Continuum of Care Reform (CCR) to be effective, adequate funding from all sources must be made available in these three areas (See Attachment A). This document focuses on residential care, which is just one component of the continuum.

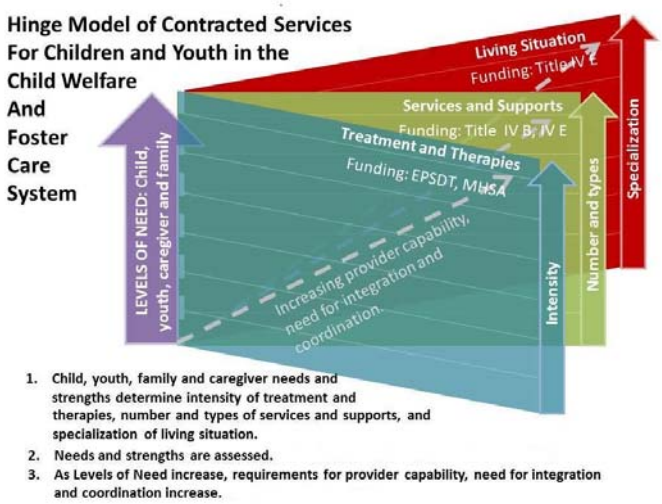
Contents

Part I: Fiscal Model Narrative

The purpose of this section is to identify the different areas of the fiscal model and provide a high level narrative of how each area of the model will be funded.

Assessment and Individualized Care

Each child will undergo a thorough assessment of their needs and strengths upon entering foster care. The goal of all foster care arrangements is to place the child in the least-restrictive setting, preferably within a family setting. Within the larger CCR model the child's living situation does not determine the services and supports or treatments and therapies that will be provided. The livings situation is related to but disconnected from services. This breaks from the traditional service array of foster care placement options where a child must go to a particular placement to receive services. However, if a child is assessed for needing 24-hour supervision, a residential living situation may be appropriate.



After the appropriate living situation has been determined, treatments and therapies outlined, and necessary services and supports identified, adequate funding from various sources will provide the resources to effectively administer a program to meet all of the child's needs while in foster care.

Levels of Supervision

CDSS initially proposed different levels of supervision within residential care but eventually found the programmatic impact, assessment requirements, and fiscal characteristics of such a proposal undesirable. The difficulties with different levels of supervision within residential care include:

1) The ability to accurately assess a child's supervision needs apart from their treatment, therapy, service, and support needs. Levels of supervision impact the IV-E allowable cost areas and therefore must be separately identified. Residential care is itself the most restrictive environment—as compared to treatment foster care, foster homes, etc.—and imposing another stratum of 24-hour supervision options was impractical.
2) If a child receives funding based on their supervision need, how does a provider ensure that each child is receiving the correlated supervision (i.e., child to staff ratio) and how does the State provide oversight and audit such supervision? This would require the State to impose child to staff ratios, which could inhibit the flexibility of providers.

It is assumed that children with 24-hour supervision needs will most often require residential care. Therefore, what determines a "difficulty of care" with children in the residential setting is the treatments, therapies, services, and supports they and their families' require, not their supervision, which will receive adequate funding separately.

Funding the Living Situation

Within residential care a child's living situation, commonly known as "board and care," is the child care and supervision plus the administrative cost of providing that care and supervision. Title IV-E of the Social Security Act[1] is an important funding stream for foster care costs. It provides for federal reimbursement for a portion of the maintenance and administrative costs of foster care for children who meet specified federal eligibility requirements. In California, the federal share is 50 percent. The federal funds help offset the State and local costs of providing foster care to children. It is California's intention to maximize IV-E funding, when appropriate. It is county realignment funding, matched by a 50% reimbursement from IV-E funding that provides for allowable living situation expenses.

Staffing Drives Cost

A child's living situation while in residential care differs from most other foster care settings in that full-time supervision must be provided. As a result, costs are significantly higher in residential care programs due to this increased staffing need. Therefore, a representative staffing model will be developed from a cost-based analysis of California residential care providers. This model will then be used to calculate **a base rate** that provides for living situation expenses and reasonable administrative costs.

Base Rate vs. Rate Classification Level (RCL)

The base rate concept is significantly different than the existing RCL payment made to providers. In the current residential care system, providers are given a RCL based on the amount of "points" for their staff level of education, training, and work experience. The higher the staffing and their qualifications, the more points a program receives. The more points, the higher the RCL. The higher the RCL, the higher the rate paid. With the RCL system, the rate is not directly tied to any assessment of individual needs of the child, simply on the staffing pattern of the program. The provider receives the corresponding RCL payment regardless of what services they deliver.

With the base rate concept, residential care programs will no longer be differentiated by RCL. Instead, they will receive a standard statewide rate for provision of adequate child care and supervision. Flexible funding and individual customization of services occur in the other two cost categories: treatments & therapies and supports & services.

[1] 42 U.S.C. §§ 671-679b

Funding of Treatments and Therapies

The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is the child health component of Medicaid. It's required in every state and is designed to improve the health of low-income children, by financing appropriate and necessary pediatric services. Under Title XIX, this benefit is funded with federal financial participation funds that are matched with state and county dollars to provide **medically necessary procedure or treatment services** needed to correct or ameliorate a defect, physical illness, mental illness or a condition, even if the service or item is not otherwise included in the State's Medicaid Plan[2]. A child will receive treatment and therapy services based on medical necessity as outlined in Medi-Cal eligibility criteria.

Required Mental Health Component

It is the intention of CDSS to develop a statewide fiscal model that maximizes EPSDT funds for the delivery of mental health services while a child is in foster care. To accomplish this, all residential care programs will need to meet the criteria for gaining access to EPSDT funding. CDSS will work with our colleagues in the counties to build this ability and those at California Department of Health Care Services (DHCS) to develop a rate-setting methodology for maximizing utilization and participation under the EPSDT program. Currently, many rate-setting methodologies for EPSDT funds are being explored such as cost reimbursement, capitation, and fee-for-service models.

Funding of Services and Supports

Services and supports are typically those activities that do not meet the criteria for IV-E or EPSDT reimbursement funds. As a result most services and supports are funded primarily with county realignment funds. However, there are a limited number of activities that may meet the criteria for reimbursement by IV-E or EPSDT (administration of social work, prevention services, etc.). The services and supports needed for each child and his/her family is determined and defined by an assessment tool and the team decision making process.

Cost Sharing

Within the CCR model the activities and responsibilities of staff may vary. As these duties change, different funding sources are used for the different activities being completed. For example, daily supervision staff whose time is normally an IV-E allowable cost could potentially be billed to EPSDT when collaborating with the Child and Family Team regarding treatment decisions. CDSS is proposing to allow flexibility in staff activities, along with access to multiple funding sources so that residential care programs can adapt to the individual needs of all their clients.

[2] Title 22, California Code of Regulations (CCR), Sections 51184; 51242; 51340; 51532

Part II: Rate Methodology

The purpose of the next section is to lay out the methodology for developing the residential care rate, assumptions, and data supporting the methodology.

Supervision and Wages as Main Cost Driver

The Living Situation portion of a residential care program has essentially four main cost areas:

- Daily Supervision
- Administration
- Direct Child-Related Expenses
- Indirect Child-Related Expenses

The residential care rate itself has two main components: funding sources and cost drivers. In California, board and care rates are funded through county funding streams with a 50/50 match for all Title IV-E allowable costs. All four areas of a child's living situation include Title IV-E allowable costs. In an effort to maximize federal funding, this has not changed with the new rate structure.

In any residential care program, it is the daily supervision of children that drives cost. The department conducted a study of 23 California residential care providers. The costs of thirteen RCL programs (Seven RCL 12 and Six RCL 14) were analyzed for three different fiscal years (2009, 2011, and 2012). In addition, cost data from 2011 for all Residentially Based Services (RBS) pilot programs was also analyzed. The average cost for direct child care staffing varied by program model. On average, the RCL programs spend approximately **50%** of their budget on daily supervision, as compared with **51%** by RBS providers. CDSS also compared the costs of the RCL programs of the same RBS providers and more of the budget was allocated to supervision on the RCL side of the house (**60%**).

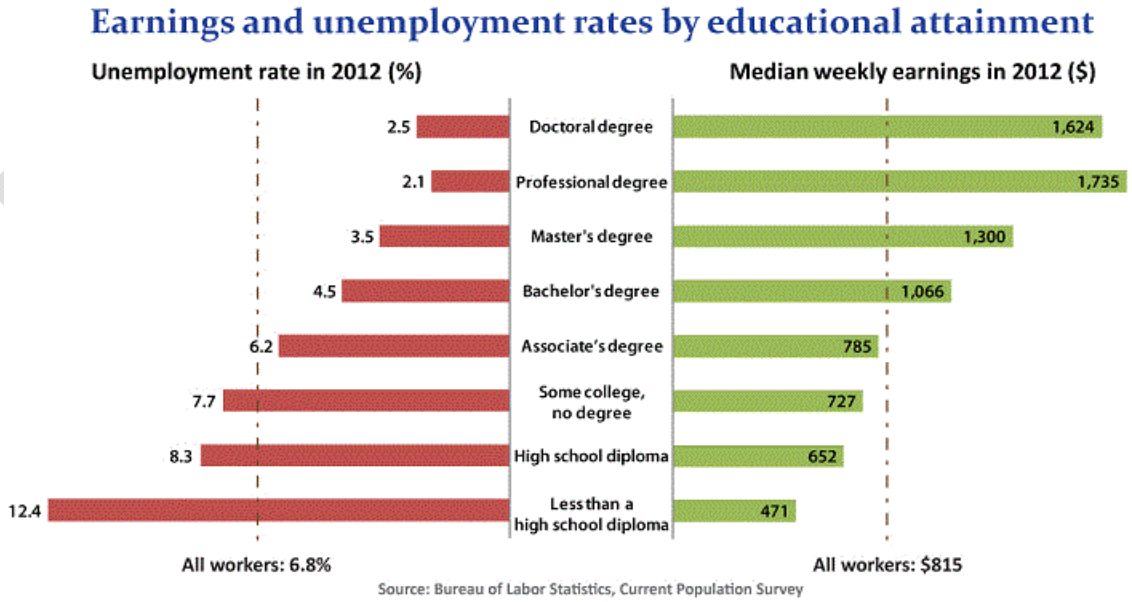
Knowing that supervision is approximately **51%** of an average program's expenses, by generating the cost to provide adequate supervision, the total rate could be calculated (i.e., the total rate is generated by the ratio of the cost of supervision to the total).

Adequate Staffing Wages & Fringe Benefits

The daily supervision portion of the residential care rate is determined by two factors: child to staff ratio and child care staff wages, including corresponding "fringe benefits." Typical fringe benefits include FICA Employer Tax, Unemployment Coverage (State & Federal), Workers' Compensation Insurance, Medical Insurance, and Retirement.

One of the recommendations of the CCR is to increase hiring qualifications and training requirements of daily supervision staff. To ensure that residential care programs are able to cover the cost of more qualified and educated staff, it was important to utilize an appropriate wage for calculating the staffing cost. The United States Bureau of Labor Statistics (BLS) does not track employment data for child supervision occupations specifically related to child welfare. Therefore the types of positions used within a residential setting were defined and matched to equivalent positions listed by the BLS under the section for Community and Social Services Occupations and Personal Care Service Occupations. Subsequently staff median hourly wages were set using the May 2012 Occupational Employment and Wage Estimates for California:

Occupation Title	BLS Occupation Code	Median Hourly Wage
Childcare Workers	39-9011	$11.06
Child, Family and School Social Workers	21-1021	$22.82
Community and Social Service Specialists	21-1798	$22.02
First-Line Supervisors of Personal Service Workers	39-1021	$19.22
All Employees with Bachelor's Degree (Nationwide)	-	$24.22



From this data it was determined that per hour was an adequate wage for direct care staff with a bachelor's degree and for first-line supervisors. This does not include fringe benefits which are added on top of the hourly wage before calculation.

Based on a review of the June 2013 BLS Employer Cost for Employee Compensation report, a rate of of the total hourly wage was determined for fringe benefits. This figure didn't greatly vary across occupational groups and therefore was used as the standard for the residential rate calculation. With the base hourly wages, in addition to benefits, the total hourly wages used for the calculation was for direct child care staff and direct line supervisors, resulting in a total monthly supervision cost of .

EPSDT Cost Sharing for Direct Care Staff

After analysis of the Residentially Based Services (RBS) pilot and feedback from providers it has been determined that in fact direct care staff dedicate a significant portion of their time to EPSDT billable activities. Therefore an "EPDST Cost Sharing Adjustment" has been included in the residential care rate methodology.

Rate Methodology Order of Operation

The basic order of operation to develop the residential care rates is as follows:

1. Identify a base hourly wage for direct child care staff and first-line supervisors in California.
2. Identify a fringe benefit rate as a percentage of total wages.
3. Identify appropriate child to staff ratios.
4. Calculate the needed full time equivalencies (FTEs) needed to provide 24-hour supervision 365 days of the year.
5. Calculate the annual cost of daily supervision.
6. Calculate monthly cost of daily supervision and divide by the number of children () to determine the monthly daily supervision cost per child.
7. Apply the validated cost-based percentage of daily supervision in typical residential care program (**51%**) to generate the total rate (100%).
8. Add occupancy rate () adjustment to total.
9. Add per child training adjustment to total.
10. Subtract EPSDT cost sharing adjustment from total.

This order of operation can be seen on Attachment B.

Fiscal Model Review and Future Rate Setting

To ensure that funds are being used appropriately, CDSS will conduct regular financial audits for the life of the residential care program, as well as an annual review of costs and the use of IV-E funds for a period following the CCR implementation. This will help all parties understand actual costs and how to most effectively utilize all available funding sources.

Future Rate Setting

The methodology to determine the initial residential care rate is used as a guide to identify appropriate funding practices based on current available data. After the new rate implementation the State, in collaboration with its partners, will develop a process for ongoing rate setting. It is expected that best practices, actual costs, and further data analysis of the implementation process will provide more precise details of the effects of the proposed fiscal model. In order to conduct an accurate and appropriate ongoing rate setting methodology, it is important that data is reported and collected in a standardized and usable format.

Training Costs

CDSS recognizes that the proposal to increase annual training requirements to 40 hours annually creates an additional cost to providers. Therefore the residential care rate methodology includes a "training adjustment" to account for the cost of funding additional staff while others are attending training.

Cost of Living Adjustments

Current cost of living adjustments (COLAs) for residential care rates are tied to the California Necessity Index (CNI). As the CNI increases, so does the residential care rate. The current adjustment process is integrated with the RCL points system. At a future date the State will determine the appropriate method for applying a cost of living adjustment (COLA) to the residential care rate in the proposed fiscal model.

Fiscal & Program Audits

Under the RCL system, program audits occur by reviewing points. If funding is no longer driven by RCL points, program audits may need to take on a different role in the new system.

Fiscal audits center on ensuring providers are claiming costs appropriately. Therefore fiscal auditing will continue to revolve around funding eligibility and allowable costs. Providers will be required to submit regular cost reports that detail activities and actual costs in the different cost areas. Fiscal audits will ensure that costs are being correctly billed and that funding is being used appropriately.

Fiscal Incentive Options

In an effort to identify a way to incentivize positive outcomes for residential care programs within the rate structure above, several options are available.

1. **Incentive for Sustained Favorable Discharge** – Residential care is by far the most expensive form of care within the foster system. The program model being adopted in California focuses on quality individualized care and not necessarily the time in care. This method awards a provider with an incentive payment for preparing a child for a lower level of care (FFA, Kin, etc.) and the placement is sustained for an identified period of time. This would ideally result in a net savings for the county, creating a potential source for the incentive payments. Total cost may not reduce, but outcomes would improve.

2. **Permanency Incentive** – Providers receive a flat incentive payment for each successful adoption. This could be time sensitive or not. This may be more effectively combined with an incentive for adoptive parents as well.

3. **Case Rate with Flexibility** – Given that providers could receive children with varying levels of supervision needs (based on staff to child ratios), there is a potential to generate savings by those effective providers who can produce favorable outcomes with minimal staffing. For example, if a provider is receiving a rate that provides for staffing for 6 children, say 3 full time staff, a savings could be generated if that provider can meet the outcomes with only two staff. To ensure a minimal level of staffing is maintained, regulations would need to be adopted.

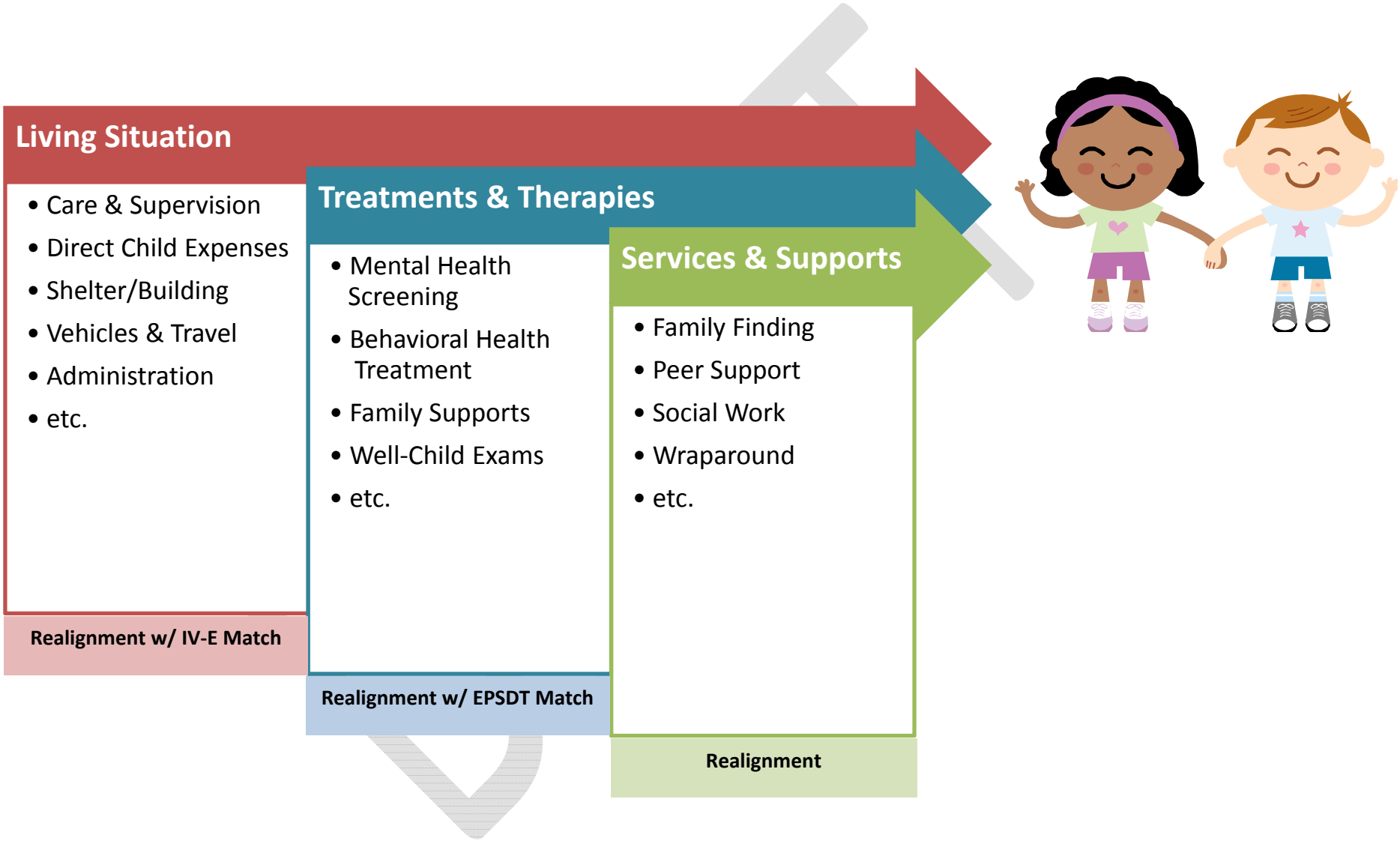
Accountability Options for California

It could be argued that the nature of Title IV-E funding is in itself a disincentive for providers to move children towards permanency. Providers receive their funding by having children in their care, not by moving them to other living situations. On the other hand, allowing providers to earn incentives for good performance may also require a system that provides accountability for poor performance. Providers must be held accountable for not meeting benchmarks and milestones regarding performance measures and outcomes. Some disincentive options include:

1. **Annual Reduction of Rate** – A provider's performance is aggregated annually and measured against desired outcomes. If certain thresholds are not met, the provider takes a reduction in their rate (calculated from the base rate, not current rate) for the following year.

2. **Market Dynamic** – Through a public "grading" process let the results of a provider's ability/inability to meet identified performance measures and outcomes influence public opinion and ultimately placement decisions. The result being that, a provider's lack of performance could result in fewer placements made in their program.

Attachment A: Residential Care Services and Funding Visual



Attachment B: Residential Care Rate Order of Operation

3:1 Staffing Ratio (Day) and 6:1 Staffing Ratio (Night)

First Day Shift	Second Day Shift	Night Shift
4.2 staff FTEs **1.4 supervisor FTEs**	**4.2 staff FTEs** **1.4 supervisor FTEs**	**1.4 staff FTEs** **1.4 supervisor FTEs**

(9.8 FTEs @ $18/hr
4.2 FTEs @ $20/hr)

\+ 30 % benefits

$774,446 per year

÷ 12 months

$64,537 per month

÷ 12 children

$5,976 Daily Supervision (51%)
$2,343 Admin (20%)
$2,578 Indirect Costs (22%)
\+ $820 Child-Related Costs (7%)

$11,717 before adjustments (100%)

\+ $1,172 Occupancy Adjustment
\+ $103 Training Adjustment
\- $2,988 EPSDT Participation Adjustment

$10,004 Total Rate

Data	1	No. of Children	12
	2	Direct Care Staff Base Wage	$18.00
	3	First Line Supervisor Base Wage	$20.00
	4	Benefits Rate (percent of total wage)	30%
	5	Assumed Direct Care Staff Time Billed to EPSDT:	50%
	6	Assumed Occupancy Rate:	90%

Direct Care Staff	7	Hourly Wage (with benefits)	$25.71
	8	Children to Staff (Day)	3
	10	Children to Staff (Night)	6
	12	Day Shifts FTEs	8.4
	13	Night Shift FTEs	1.4
	14	Total FTEs	9.8
	15	Total Cost per Day (w/o benefits)	$1,005.24
	16	Total Cost per Day (w/benefits)	$1,436.05
	17	Total Monthly Staff Cost per Child	$4,044
Supervisors	18	First Line Supervisor Wage (with benefits)	$28.57
	19	Staff to Supervisor (Day)	10
	21	Staff to Supervisor (Night)	10
	23	Supervisors (Day) FTEs	2.8
	24	Supervisors (Night) FTEs	1.4
	25	Total FTEs	4.2
	26	Total Cost per Day (w/o benefits)	$480.00
	27	Total Cost per Day (w/benefits)	$685.71
	28	Total Monthly Supervisor Cost per Child	$1,931
	32	TOTAL SUPERVISION MONTHLY COST PER CHILD	$5,976

Training	33	Annual Training Hours Required	40
	34	Total FTEs that Require Training	14.0
	35	Hours of Annual Training for Staff	392
	36	Hours of Annual Training for Supervisors	168
	37	Monthly Cost of Training	$1,241
	38	MONTHLY COST OF TRAINING PER CHILD*	$103

Calculation	39	Daily Supervision	51%	$5,976
	40	Admin	20%	$2,343
	41	Indirect Costs	22%	$2,578
	42	Child-Related Costs	7%	$820
	43	Total Generated from Supervision Ratio		$11,717
	44	Occupancy Adjustment		$1,172
	45	Training Adjustment		$103
	46	EPSDT Participation Adjustment		-$2,988
	47	TOTAL RESIDENTIAL CARE RATE (w/ training)		$10,004

= Editable Field

Assumptions

Supervisor is providing direct supervision and counts toward staffing ratio.

Direct costs fixed at $820.

Total rate includes occupancy calculation.

Benefits rate includes funding for paid leave.

Daily supervision includes funding for coverage during training. Training cost added after all calculations.

Direct care staff will be involved in activities that will be billed to EPSDT and not IV-E. To ensure that funding is appropriately allocated, an "EPSDT Cost Sharing Adjustment" was included.

Residential care rate model is for California programs only.